CITGO Petroleum Corporation
HOURLY BENEFITS ENROLLMENT FORM

(With HMO Area)

NAME FIRST MIDDLE LAST	SOCIAL SECURITY NO.		
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL PHONE (OPTIONAL)	WORK PHONE	
POSITION TITLE	HIRE DATE	PERNR	

IMPORTANT ENROLLMENT INFORMATION - READ CAREFULLY

Under the CITGO Medical, Dental, Vision and Life Insurance programs, if you are covered for benefits as an employee, you cannot be covered as a dependent. Eligible children can only be covered by one parent under the Medical, Dental, Vision and Life Insurance programs if both parents are CITGO employees and/or retirees.

In consideration of the above Plan provisions, are you currently married to or the dependent of another CITGO Employee or Retiree?
☐ **Yes** ☐ **No**

If "Yes", please confirm the name and Social Security Number _____

MEDICAL

MEDICAL OPTION (Check Only One)

NETWORK AREA	NON-NETWORK AREA	MEDICAL LEVEL OF COVERAGE (Check Only One)
☐ Exclusive Provider Option ☐ Preferred Provider Option ☐ High Deductible Health Plan ☐ Aetna HMO **(Must Complete Aetna Form also)** ☐ WAIVE Coverage	☐ Non-Network Option ☐ WAIVE Coverage **Note: The HDHP is for employees in all network areas.**	☐ Employee Only ☐ Employee and Child(ren) ☐ Employee and Spouse ☐ Employee and Family

DENTAL

DENTAL OPTION - (Check Only One)

☐ Dental PPO Option ☐ WAIVE Coverage

DENTAL LEVEL OF COVERAGE - (Check Only One)

☐ Employee Only ☐ Employee & Child(ren)
☐ Employee & Spouse ☐ Family

VISION

VISION OPTION - (Check Only One)

☐ Vision Program ☐ WAIVE Coverage

VISION LEVEL OF COVERAGE - (Check Only One)

☐ Employee Only ☐ Employee & Child(ren)
☐ Employee & Spouse ☐ Family

PERSONAL ACCIDENT

PERSONAL ACCIDENT

Maximum amount allowed is 10 x your Annual Base Salary up to $500,000 and the minimum coverage amount is $10,000
You must elect coverage in multiples of $5,000.

Amount of Coverage: $_____

PERSONAL ACCIDENT LEVEL OF COVERAGE
(Check Only One)

☐ Employee Only ☐ WAIVE Coverage
☐ Family

LIFE INSURANCE

OPTIONAL LIFE

You may elect a combined coverage of 3 times your annual base pay under Pre-Retirement and Post Retirement Life Insurance (you may only elect a maximum of 2X Post-Retirement).

DEPENDENT LIFE

You may elect dependent child coverage for all eligible dependents.

Pre-Retirement Life (Check Only One)	Post-Retirement Life (Check Only One)	Dependent Life (Check Only One)
☐ 1 x base salary ☐ 2 x base salary ☐ 3 x base salary ☐ Waive Coverage Statement of Health required for late enrollment.	☐ 1 x base salary ☐ 2 x base salary ☐ Waive Coverage Statement of Health required for late enrollment.	☐ $7,500 for Spouse / $1,500 Child ☐ Waive Coverage Statement of Health required for late enrollment.

Dependent Name	Relation to you	Date of Birth	Dependent SSN	Medical	Dental	Vision	Dep Life	Pers Acc
Leslie Example	Employee	mm/dd/yy	123-45-6789	Y ☒ N ☐	Y ☐ N ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
		/ /	- -	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

Your elections cannot be changed until the next Annual Election period unless you or any of your eligible dependents experience a qualifying status change event. Requests for coverage changes related to a qualified status change must be made within 31 days of the event and be consistent with the changes permitted under Internal Revenue Code Section 125 Cafeteria Plan rules. More information on qualified status changes can be found outlined in the Summary Plan Description.

My signature below indicates that I have read this enrollment form and the descriptive material on the plans, and that I understand the options available to me. My signature further indicates that I am authorizing regular deductions from my pay on a tax-free basis (where applicable). I understand that my tax-free contributions under these plans are deducted from my pay before federal income, state income (where applicable), and Social Security taxes and that this may slightly reduce my Social Security benefits.

______________________________________ ______________________________

Employee Signature **Date**

Please be sure to create a duplicate copy of this signed and dated form by scanning electronically or by using a copy machine so you will have a copy for your records.

THIS SECTION IS FOR BENEFITS DEPARTMENT USE ONLY

STATEMENT OF HEALTH REQUIREMENT REVIEW

Pre-Retirement Life	**Post-Retirement Life**	**Dependent Life**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Key this amount $________________	Key this amount $________________	Key this amount $________________
Amount pending approval from underwriting $________________	Amount pending approval from underwriting $________________	Amount pending approval from underwriting $________________
Reviewer Initials ___________	Reviewer Initials ___________	Reviewer Initials ___________